kynect
Kentucky's Healthcare Connection

APPENDIX A

Health Coverage from Jobs

Use this appendix only if someone in the household is eligible for health coverage from a job. This includes spouse and dependents that are eligible for employer sponsored health coverage, even if the employee is not on the health coverage application. Contact the employer who offers coverage to help you answer these questions. **Complete and send this page (one for each job that offers coverage) with your health coverage application.**

EMPLOYEE Information

1. Employee Name (First, Middle, Last)	2. Employee Social Security Number

EMPLOYER Information

3. Employer Name		4. Employer Identification Number (EIN)
5. Employer Address		
6. City	7. State	8. Zip Code
9. Employer Contact Name		10. Employer Contact Phone Number
11. Employer Contact Email		

Who is offered coverage by this employer?

12. Does this employer currently **offer** coverage to anyone on your health coverage application?

☐**YES. If yes**, list the names of the persons who are **offered** coverage **or** who are **enrolled** in the coverage offered by this employer: **(Check the box if offered coverage and/or enrolled in coverage for each person below)**

Name: _____ ☐ Offered ☐ Enrolled

Name: _____ ☐ Offered ☐ Enrolled

☐**NO**. **If no**, stop using this appendix.

Tell us about the health plan offered by this employer

13. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if the employee received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
   a. How much would the employee have to pay in premiums for that plan? $ _____
   b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

14. What change will the employer make for the new plan year (if known)?
   ☐ Employer won't offer health coverage. If so, what is the last day of coverage? _____
   ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 13.)
      a. How much will the employee have to pay in premiums for that plan? $
      b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly
      c. Date of Change: _____
   ☐ Employer will continue to offer health coverage. If so, are you planning on enrolling in that coverage?
      ☐ **Yes**. **If yes**, when will coverage begin? _____
      ☐ **No. If no**, when will coverage end? _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

If you need help with your application or to apply faster online, go to **www.kynect.ky.gov** or call **1-855-4kynect (459-6328)**. Para ayuda en Español, llame gratis al 1-855-4kynect (459-6328).